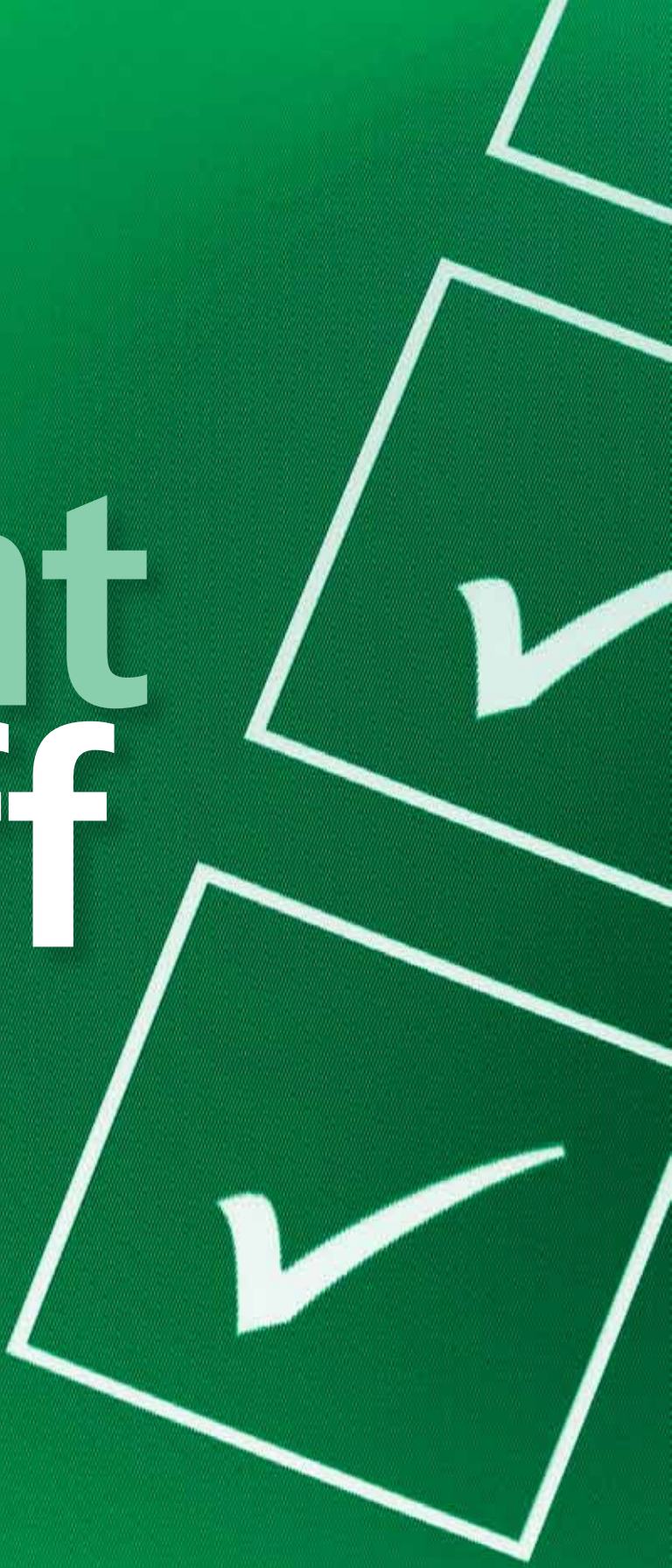
The Right Stuff

by Theron Post and Rosemary Schuman



In 50 Words Or Less

- An organization's leadership spends long hours making decisions but often fails to follow up and see how those decisions are implemented.
- To address that gap between theory and practice, a healthcare organization used deployment checks and saw its entire operation improve.

Use deployment checks to verify things are being done correctly

LEADERS AND MANAGERS spend considerable time in meetings, setting the future direction of the organization and working with front-line managers to ensure operations are efficient, effective and meeting the needs of customers.

The reality for many leaders is they are engaged in making decisions that affect everyone in the organization, but most of them have little evidence of whether decisions are being implemented as intended and whether implementation is achieving the intended outcome. As a result, these decisions are made and implemented without a fact-based process for understanding how well they are deployed and whether they are achieving their goals.

To better understand this gap, the Nebraska Medical Center (NMC) in Omaha developed deployment checks as an information-gathering tool to understand the effectiveness of leadership and culture-building efforts.

While insightful and meaningful information was collected about the deployment of these influential processes, NMC leaders realized the real value was a deeper, more personal understanding of what it feels like from a process perspective to walk in their employees' shoes and how the most well-intended culture-building processes were not being fully implemented as designed.

At NMC, the Journey to Performance Excellence (JTPE) team is assigned the task of developing, advising and monitoring the medical center's continuous improvement journey. To address these complexities, the team has been busy the last several years using lean Six Sigma tools to identify waste and redesign processes. Some of the team's initiatives have led the organization to high levels of performance. On the other hand, the JTPE team knew other processes were not doing as well—a suspicion that was verified by certain areas of lower performance.

The team asked two questions that led to an important conclusion: How do you know that key processes are being done the same way by everyone and at all levels? And if so, how well are these processes working, and what are the opportunities to make them work better?

The team quickly realized one of the biggest opportunities involved collecting data and information regarding how leadership's decisions were working for everyone in the organization so the team could make effective improvements to these key approaches and take performance to the next level.

Firsthand look

In the 1980s, Tom Peters helped popularize an unstructured management approach in which he challenged leaders and managers to get out from behind their desks and visit the places where the work is happening to learn firsthand about how things are functioning.[1]

For lean organizations, the *gemba* walk is a method of taking leaders to the manufacturing floor to see where the problems are occurring so they identify opportunities for improvement.[2] In *Hardwiring Excellence*, author Clint Studer developed an approach to improve employee satisfaction called "rounding for outcomes."[3]

All of these approaches are focused on equipping leaders with knowledge about the effectiveness of daily work processes and how well their organization has created an engaged workforce culture through the use of continuous improvement systems and tools.

To connect NMC's leaders with the current state of continuous improvement deployment, the JTPE team was asked to develop a process that would connect leaders with front-line staff in a way that would lead to a genuine and accurate assessment of the organization's key processes responsible for developing NMC's culture around its mission and strategic objectives.

There was also a need to begin a conversation to improve and integrate these approaches and increase effectiveness. Essentially, the new process would be enhancing the monitoring process used to develop and deploy NMC's continuous improvement culture.

The paradigm shift for NMC was moving the organization's work from using the Malcolm Baldrige National Quality Award application as an external assessment process to using it as an internal assessment process integrated within the annual strategic planning cycle.

In essence, the new process would need to systematically generate opportunities for improvement without waiting for the external feedback report. This would give the medical center critical feedback more quickly to reduce the turnaround time on implementing future refinements and improvements.

For example, the medical center had processes in place so it would always be ready for accreditation and regulatory visits. These readiness processes help NMC proactively identify potential problems and resolve concerns before they affect patient care. NMC's breakthrough came when the organization developed a similar approach to assess organizational culture development efforts through the use of deployment checks.

Start to define

The identification and integration of key processes and approaches that create an organizational culture is one of the most difficult tasks for any organization to master. To that end, the JTPE team began working to define the actions and activities it expected everyone in the organization to execute with patients, family members of patients and one another.

This step was made easier by using the organization's most recent Baldrige award applications, which

"We are working on **so many things.** How will we ever get anything done **if we can't narrow it down** to a few critical things?"

defined the organizational processes that applied to everyone and built the continuous improvement culture. This definition forced NMC to eliminate everything but the few key processes and systems that are critical to the development of the organization's culture. After much discussion and system-level process mapping, the JTPE team realized this narrowed-down list of processes leveraged everything else to increase organizational effectiveness.

NMC identified six key processes and approaches that shape its organizational culture:

1. Mission.
2. Pillars of excellence.
3. Patient first.
4. Priority ladder.
5. Scorecards and dashboards.
6. Communication of decisions.

After the key processes and approaches were determined, the JTPE team members embarked on defining what they expected to hear and see at the bedside of patients, and how would they know the process was understood, routinely practiced and effective when they asked the workforce.

To do this, the JTPE team envisioned what each process outcome would look like in an ideal state, which essentially became the check or standard the medical center wanted to see from every employee. It took reflection and extensive dialogue to ensure the questions focused on the area the checks were intended to address.

The JTPE team was challenged to translate corporate lingo into questions that could be easily understood by the entire workforce—a process that took multiple revisions to get right. For example, the question, "What are your unit-based balanced score measures?" was rewritten so it now reads, "How do you know what is the most important problem your unit is working on right now?"

To quantify each answer, the team developed a continuum that scored responses ranging from "I don't know what you are talking about," to "Monthly, we look at how we are doing on infection rates and patient falls, then we plan how to fix it and what to do differently."

The result was a scoring rubric that clearly defined what the team expected to see within each dimension of the deployment check broken into three areas: early, moderate and strong (see Figure 1, pp. 28-29).

Free from bias

After deciding senior leaders and the JTPE team would jointly conduct the checks, the JTPE team began to determine how to conduct the deployment checks of managers and other employees to ensure information collected was unbiased.

A natural and understandable reaction by a department manager would be to put his or her best foot forward, even if there were gaps that needed to be addressed. So a decision was made to conduct the manager and front-line employee process checks separately to get better data regarding the effectiveness of deployment.

This decision came with some reticence, however. If the managers believed they were being audited and that the outcome of the checks would be used against them in any way, they might circumvent the process. To overcome this potential barrier, the team reinforced the idea that the deployment check process was designed to be a learning tool and that the results would not be used in any way as an evaluation of a specific manager's performance.

The senior leaders and JTPE team needed to agree the outcomes would provide information to assess the organization's ability to deploy culture-building processes effectively. Deployment checks were conducted during a period of 30 to 45 days, and the data were kept on an Excel spreadsheet for analysis and decision making for next steps.

On completion of the deployment checks, the data were aggregated and analyzed by senior leaders with help from an external facilitator. The data indicated the systems and processes that were more fully de-

Deployment tally sheet / FIGURE 1

Tally "M" for manager response. Tally "S" for staff member response.						Score	Comments
Balanced scorecard (BSC) and goal setting		**Early (1)**	**Moderate (2)**	**Strong (3)**	**Learning cycles (4)**		
1. What is our organization's mission statement?		Can't recite "serious medicine, extraordinary care"	States "serious medicine, extraordinary care"	Can explain some of underlying meaning behind "serious medicine, extraordinary care"	N/A		
	Tally:						
2. What are our pillars of excellence?		Can identify the pillars conceptually	Can name some	Can name or read 5/5	N/A		
	Tally:						
3. How does your work directly support the goals of the organization?		Has personal goals defined by a supervisor	Remembers completing an "I will" card in the past	States goals from "I will" card from memory and links to unit goals	Can state goals that have been achieved and speak to improvements		
	Tally:						
4. How are you kept informed about progress toward achieving unit goals?		Knows generally that unit-based goals exist	"We get information monthly on our unit-based goals"	Knows one of the unit-based goals	Knows specific work that is directed toward improving department goals		
	Tally:						
5. How are you kept informed about progress toward achieving organizational goals?		Knows generally that we have organization-based goals	Gets information on a regular basis on how the organization is performing	Knows which organizational goals relate to the unit	Can tell what the unit has done to make an impact on the organizational goal		
	Tally:						
Probe: Have you ever completed an "I will" card? Have you heard the term BSC? Are you aware of your unit's BSC goals? What improvement activities are you involved in that affect these goals?							
					Total item score:		

ployed were those that had been in place for a longer period of time. The lower-performing areas were processes introduced more recently.

This validated that many of these processes and approaches were on the way to shaping NMC's culture. But continued persistence to reinforce cycles of improvement would help refine and integrate these approaches to enhance effectiveness.

This analysis was supported by the recent introduction of individual goals through "I will" cards, which are aimed at creating goals for all staff that are linked to departmental and organizational goals NMC can work on to increase effectiveness.

Overall, the survey results indicated managers were at a moderate performance level rating, while the other employees scored just above the early level rating. This analysis has led to the development of action plans to address these gaps during the next deployment cycle.

Cutting confusion

Like many organizations, it's a challenge for NMC to find a focus in the complex healthcare environment. So it wasn't surprising when NMC's senior leaders concluded that too many priorities led to confusion among the workforce.

While leaders knew they needed to provide the organization greater focus, nothing propelled them to action as much as spending two hours with front-line staff asking each to name the most important thing on which NMC is focused. When hearing the answers, leaders were surprised that every answer was correct, yet almost every answer was different.

When NMC rolled the balanced scorecard down to

Deployment tally sheet / FIGURE 1 (CONTINUED)

Tally "M" for manager response. Tally "S" for staff member response.						Score	Comments
Customer service		**Early (1)**	**Moderate (2)**	**Strong (3)**	**Learning cycles (4)**		
6. Who are your most important customers and what do they require from your services?		Identifies "patient first"	Can identify some of the "patient first" service commitments	Can identify a time when changed behavior due to "patient first" service commitment	Has increased understanding of customer requirements through continuous quality improvement process		
	Tally:						
7. How do you use the "patient first" priority ladder when making daily decisions about work priorities?		Can identify the priority ladder conceptually	Knows the components of the priority ladder	Can state a time when priority ladder was used to make decisions	Can state how priority ladder has influenced work priorities		
	Tally:						
Probe: Have the organization's priorities regarding customer service changed over time?							
					Total item score:		
Communication		**Early (1)**	**Moderate (2)**	**Strong (3)**	**Learning cycles (4)**		
8. How are major decisions about the organization typically communicated to you?		Cites directional (newsletter, intranet, email)	Cites bidirectional (forums, manager, unit-based council)	Cites time when gave input into organizational decision	Cites time when input influenced organizational decision		
	Tally:						
9. What was the last major organizational decision or announcement you heard?		Cites basic knowledge	Cites moderate knowledge	Cites strong knowledge	Cites time when input influenced organizational decision		
	Tally:						
Probe: How do you give input on decisions?							
					Total item score:		
Date:				Location:			
Surveyer:				Total number of employees surveyed:			

the employee level and the process experts told leaders they would be asking employees to focus on only two things, leaders were very uncomfortable. "We have so much to work on," the leaders said. "We will never get anything done if we only work on two things."

After the deployment checks, the sentiment among leadership was, "We are working on so many things. How will we ever get anything done if we can't narrow it down to a few critical things?" This conclusion challenged the senior team to narrow the focus of NMC's strategic plan, which is being redeployed this year.

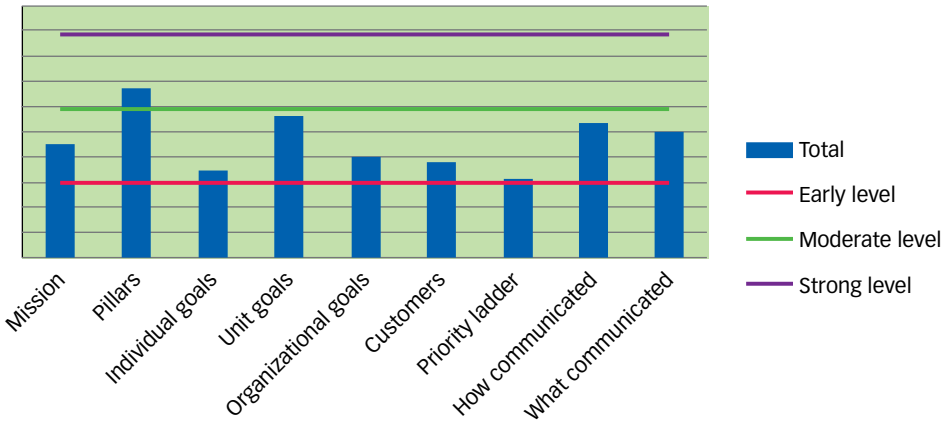
The results from the deployment checks are noted in Figures 2 and 3 (p. 30). Again, managers were rated separately from staff to better understand what each group knew about NMC's culture-building processes.

The deployment checks generated some unintended learning that was significant for leaders and JTPE team members. First, leaders needed to shift their thinking from decision maker to listener and learner.

Many leaders spend so much of their time making decisions, it is important for them to set a learning tone for the conversation. The team developed icebreaker questions and used a scribe so it wouldn't need to worry about taking notes and instead could focus on engaging with employees.

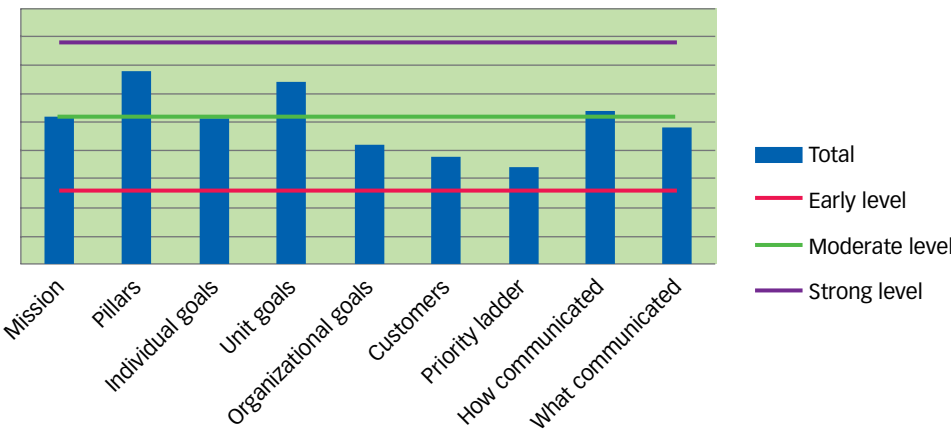
Focusing on the primary goal of engaging with employees as opposed to the secondary goal of data collection allowed the leaders to deviate from the script and make employees feel supported regardless of the outcome of the conversation.

All-staff deployment check / FIGURE 2



	Mission	Pillars of excellence	Individual goals	Unit goals	Organizational goals	Customers	Priority ladder	How communicated	What communicated
Total	90	135	69	112	81	76	63	107	100
Early level	59	59	59	59	59	59	59	59	59
Moderate level	118	118	118	118	118	118	118	118	118
Strong level	177	177	177	177	177	177	177	177	177

Managers deployment check / FIGURE 3



	Mission	Pillars of excellence	Individual goals	Unit goals	Organizational goals	Customers	Priority ladder	How communicated	What communicated
Total	26	34	26	32	21	19	17	27	24
Early level	13	13	13	13	13	13	13	13	13
Moderate level	26	26	26	26	26	26	26	26	26
Strong level	39	39	39	39	39	39	39	39	39

Overall, the leaders enjoyed getting out of their daily decision-making routines, talking directly with staff about deployment topics and having unique opportunities to listen to employees' perceptions.

The unintended outcome: Most NMC leaders better understood why these culture-building processes and strategic issues are important to the long-term success of the organization, and were reenergized to continue the journey.

Often, processes are viewed as independent and unrelated. Following the deployment check process, senior leaders had an enhanced understanding of how processes and approaches integrate to create a purposeful culture at NMC. Senior leaders concluded these processes and approaches could not reach full effectiveness until they were integrated seamlessly.

No longer blind

Going beyond the writing of the Baldrige award application and using the *Baldrige Criteria for Performance Excellence* to improve and integrate culture-building processes has fueled NMC's learning and validated the value of the journey.

Deployment checks have given senior leaders tangible information to help identify areas of improvement or blind spots. NMC realized that without this check in place, it did not have the ability to fully understand the effectiveness of creating a culture based on its mission: "Serious medicine. Extraordinary care." QP

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